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No. 84-1347

IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

SEBASTIAN REBALDO, AS CHAIRPERSON
OF THE BOARD OF TRUSTEES OF THE
UNITED OPTICAL WORKERS INSURANCE FUND,
Petitioner,

v.

MARIO CUOMO, GOVERNOR OF THE STATE OF NEW YORK;
and DAVID AXELROD, COMMISSIONER OF HEALTH
OF THE STATE OF NEW YORK,
Respondents.

On Writ of Certiorari to the United States Court of Appeals For the Second Circuit

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BRIEF *AMICUS CURIAE* OF LOCAL 338 HEALTH AND WELFARE FUND AND LOCAL 814 WELFARE FUND

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BRIEF *AMICUS CURIAE* OF LOCAL 338 HEALTH AND WELFARE FUND AND LOCAL 814 WELFARE FUND

INTEREST OF THE *AMICI*

The Trustees of the Local 338 Health and Welfare Fund and the Local 814 Welfare Fund submit this brief with the written consent of the parties pursuant to Supreme Court Rule 36.1.

The Local 338 Health and Welfare Fund and the Local 814 Welfare Fund ("the Funds") are employee welfare benefit plans within the meaning of Section 3(1) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1002(1). The Funds provide a wide variety of health and hospitalization benefits to more than 20,000 participants and their families residing in New York, New Jersey, California, Florida, Virginia, Pennsylvania and Connecticut. These benefits are funded exclusively by employer contributions made pursuant to collective bargaining agreements between various employers and Local 338 Retail, Wholesale and Department Store Union, in the case of the Local 338 Health and Welfare Fund, and Local 814, International Brotherhood of Teamsters, in the case of the Local 814 Welfare Fund.

Since its inception in 1941, the Local 338 Health and Welfare Fund has acted as its own insurer of the health benefits it provides to the individuals it covers. Hospitalization benefits provided by the Local 814 Welfare Fund are insured by Blue Cross-Blue Shield of Greater New York, Inc. ("Blue Cross"), a non-profit health service corporation operated under the requirements of Article 43 of the New York Insurance Law. N.Y. Ins. Law §§ 4301-15 (McKinney Supp. 1984) ("Article 43"). The Trustees of the Local 814 Welfare Fund are presently considering self-insurance of hospital benefits because they are dissatisfied with the excessive cost and benefit program requirements of insuring benefits through Blue Cross.

Amici are vitally concerned that the freedom to determine the method by which benefits are insured, and the freedom to decide the nature of the benefits which they provide, both of which are protected by ERISA, not be infringed by any States' legislation. If the decision of the Court of Appeals in this case is upheld it will deprive *Amici* of their right to determine the Funds' structure and benefits free of interference by the State.

STATEMENT OF THE CASE

This case presents the question whether a state statute which financially penalizes welfare plans for making choices relating directly to plan design can survive ERISA's far-reaching preemption of all state laws which "relate to" employee benefit plans. ERISA § 514(a), 29 U.S.C. § 1144(a). New York's Public Health Law 2807-a (6)(b), N.Y. Pub. Health Law § 2807-a(6)(b) (McKinney Supp. 1984-85) ("§ 2807-a(6)(b)"), clearly "relates to" welfare benefit plans because its purpose and effect are to discourage self-insurance by welfare plans and to encourage insurance of benefits through insurers which are mandated by law to provide specific benefits.

A. The Choice Between Self-Insurance and Third Party Coverage.

The benefits provided by an employee welfare benefit plan may be insured by the fund itself, or by an outside commercial or non-profit carrier. ERISA places the burden of this decision with the trustees of a plan. Their choice must be made "in the interest of the participants and beneficiaries and . . . for the exclusive purpose . . . of providing benefits to participants and beneficiaries . . . ." ERISA § 404(a)(1)(A)(i), 29 U.S.C. § 1104 (a)(1)(A)(i).

One of the major reasons that plan trustees have traditionally chosen to insure benefits with health service corporations such as Blue Cross is administrative. The insurer will assume the burden of the plan's day-to-day administration of claims.

A variety of reasons have supported the decision to self-insure. Enormous savings are associated with self-insurance. Funds which self-insure can institute and closely oversee cost and quality control programs. In addition, administrative costs of the plan are often halved by self-insurance. Thirdly, interest earned by the amounts which would be pre-paid to insurers as reserves

are kept by the self-insured fund. These savings made possible by self-insurance permit plans to offer participants broader and better coverage for their health needs. Self-insurance also affects the nature of benefits which a fund may provide. It permits complete flexibility relating to substantive benefits. These factors which inform a plan's decision to self-insure unequivocally establish that the *means* of benefit insurance chosen is an integral aspect of plan design affecting funding and substantive benefits.

B. The Effect of New York Public Health Law Section 2807-a(6)(b).

Section 2807-a(6)(b) of the New York Public Health Law poses a two-prong threat to the right of plan trustees to freely determine plan design. The provision first prohibits negotiation of discount charges for hospital care.[1] Such direct negotiation with hospitals had been a traditional means of non-profit insurers and self-insured groups to obtain lower costs for hospital care for their subscribers.

At the same time that the statute bans the negotiation of discounts, it automatically bestows a discount upon insurers organized and operating under Article 43 of the New York Insurance Law.[2] It is the only discount permitted under the law. Upon the effective date of Section 2807-a(6)(b), nearly all discount arrangements by self-insured and self-administered groups must be cancelled, and by the end of 1985, all must be terminated. The statute permits the temporary continuation of discounts negotiated by self-insured and self-administered groups

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[1] The prohibition by Section 2807-a(6)(b) of discount rate negotiation is imbedded within a mandate to the State's general hospitals to establish a schedule of gross charges for service sufficient to generate the revenue necessary for efficient operation.

[2] Section 2807-a(6)(b) refers to "corporations organized . . . in accordance with article nine-C of the Insurance law." Article nine-C has been recodified as Article 43.

which had already been in effect on May 1, 1982. All discounts to self-insured and self-administered groups must be terminated before January 1, 1985. By contrast, Article 43 insurers are automatically granted a rate discounted by twelve to fifteen percent. As a direct result, Section 2807-a(6)(b) creates a financial incentive to welfare plans to insure hospital benefits through an Article 43 corporation like Blue Cross. Welfare plans that decide that plan participants' needs are better served by self-insurance will pay twelve to fifteen percent more for the identical hospital care.

C. State Law Controls on Article 43 Insurers.

Article 43 of New York Insurance Law governs the organization and operation of non-profit medical and dental indemnity corporations and health or hospital service corporations. Blue Cross, the insurer of Local 814 Welfare Fund's hospitalization benefits, is a non-profit health service corporation as defined by § 4301(e) of the New York Insurance Law. Article 43 primarily regulates the internal structure and governance of non-profit insurers and sets out requirements relating to their operation as fair and sound insurers.

In addition to the regulation of the structure of non-profit insurers, Article 43 mandates the provision of numerous substantive benefits. Section 4303(a) provides that every contract issued by a health service corporation which provides coverage for in-patient care must also provide coverage for pre-admission/pre-surgical testing, emergency medical services, and home care. N.Y. Ins. Law § 4303(a). Section 4303(b) requires health service corporations which provide surgical coverage to provide coverage for second surgical opinions.[3] N.Y. Ins. Law § 4303(b). Health service corporation contracts

[3] Section 4303(a) and (b) do not apply to group contracts covering individuals employed in more than one state, or to group contracts whose benefit structure was the subject of collective bargaining affecting persons who are employed in more than one state. N.Y. Ins. Law § 4303(a)(3)(D).

which cover in-patient hospital service must also include coverage for pre-natal and maternity care.[4] N.Y. Ins. Law § 4303(c). Article 43 also imposes restrictions on the patients which may be excluded from coverage under group contracts.[5]

The effect of Section 2807-a(6)(b) is therefore not restricted to discouraging plans from acting as their own insurers of benefits. The statute, by pushing plans into the arms of Article 43 insurers, also forces these plans to provide the substantive benefits which Article 43 corporation contracts must provide.[6]

The combined effect of Section 2807-a(6)(b) and Article 43 is to encourage plans to insure benefits with an Article 43 insurer, and to provide the benefits which the New York State Legislature has deemed valuable. Section 2807-a(6)(b) thus places an impermissible burden on the exercise of the right to self-insure and determine substantive plan design.

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[4] Nursing home care, ambulatory care and the diagnosis of emotional disorders must also be made available under contracts for inpatient hospital care. N.Y. Ins. Law §§ 4303(d), (e) and (g) (respectively). Health service corporation contracts which cover medical, surgical or major medical care must make available coverage for children's preventive and primary care. N.Y. Ins. Law § 4303(j). Alcoholism and alcohol abuse diagnosis and treatment must be made available by health service corporation contracts which provide group, group remittance or school blanket coverage for inpatient and hospital care. N.Y. Ins. Law § 4303(k).

[5] Section 4305(c)(1) provides that group contracts which cover a member's spouse and dependents but terminate dependents' coverage upon their attainment of a certain age must not terminate coverage of dependent unmarried children who are incapable of self-sustaining employment because of an emotional or physical handicap or illness.

[6] Plans whose hospitalization benefits are insured by an Article 43 corporation cannot elect a contract with that corporation that does not cover the benefits which Article 43 requires. As it would violate the fiduciary duty the plan's trustees owe to participants to deny coverage which the plan has purchased, such coverage must be provided to the participants.

ARGUMENT

NEW YORK PUBLIC HEALTH LAW SECTION 2807-a(6)(b) IS PRE-EMPTED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

Section 2807-a(6)(b) of the New York Public Health Law denies self-insured employee benefit plans the vital right to negotiate discount rates with hospitals. By extinguishing this right, while at the same time affording Article 43 corporations such as Blue Cross a twelve to fifteen percent discount, Section 2807-a(6)(b) impermissibly puts self-insured employee benefit plans to a Hobson's choice: such plans must either significantly reduce their benefits so as to be able to afford the non-discounted rate, or forego their self-insured status in order to take advantage of the discount offered to Article 43 insurers such as Blue Cross. If the latter choice is made, the plans are effectively forced to offer their beneficiaries the statutorily prescribed benefits Article 43 insurers must offer.

In stark contrast to New York State's attempt to influence whether plans self-insure or insure, and what benefits they offer, ERISA places questions of plan structure and design within the sole discretion of the plan trustees. With respect to plan structure, the trustees are free to decide whether to structure a plan on an insured or self-insured basis. 29 U.S.C. § 1002(1). They are also vested with the authority to determine what benefits a plan provides, free of governmental influence and control.

Section 2807-a(6)(b) thus impermissibly attempts to regulate matters which Congress expressly left to the discretion of plan trustees. In spite of this, and in spite of the self-evident impact of Section 2807-a(6)(b) on self-insured welfare benefit plans, the court below concluded that the statute did not "relate to" employee benefit plans within the meaning of Section 514(a) of ERISA. *Rebaldo* v. *Cuomo*, 749 F.2d 133, 137-38 (2d Cir. 1984).

This conclusion directly conflicts with this Court's decisions in *Shaw* v. *Delta Air Lines, Inc.*, —— U.S. ——, 103 S.Ct. 2890 (1983) and *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981). It also ignores the plain language, legislative history and purpose of ERISA Section 514(a). 29 U.S.C. § 1144(a). Accordingly, this Court should grant the petition for a writ of *certiorari* and reverse the decision of the court below.

A. Section 2807-a(6)(b) Impermissibly Dictates The Benefit Packages Which Employee Welfare Benefit Plans Must Offer.

In *Shaw* v. *Delta Air Lines*, —— U.S. ——, 103 S.Ct. 2890, this Court established the fundamental proposition that ERISA pre-empts all laws which directly or indirectly require employee benefit plans to provide a certain kind of benefit. The laws at issue in *Shaw* were New York's Disability Benefits Law and New York's Human Rights Law. These laws, respectively, required employers to pay to their employees sick-leave benefits during pregnancy leaves and prohibited employee benefit plans from treating pregnancy differently from other disabilities.

After a thorough examination of the language and legislative history of ERISA's pre-emption clause, this Court declared that it had "no difficulty in concluding" that laws which require or prohibit the provision of specific benefits "relate to" employee benefit plans within the meaning of ERISA. *Shaw*, 103 S.Ct. at 2899. Thus, absent an express statutory exemption from pre-emption,[7] such laws are pre-empted by ERISA. *Id.*

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[7] The only state laws exempt from Section 514(a) pre-emption are those regulating insurance, banking or securities. 29 U.S.C. § 1144(b)(2)(A), and generally applicable criminal laws. 29 U.S.C. § 1144(b)(4). Additionally, state laws which relate to employee benefit plans that are not within ERISA's coverage are exempt from pre-emption. 29 U.S.C. § 1003(b).

In accordance with *Shaw*, the lower federal courts have overwhelmingly concluded that any state law which requires or prohibits the provision of certain benefits to certain participants is within the broad pre-emptive reach of Section 514(a).[8] *See, e.g., Champion International Corp.* v. *Brown*, 731 F.2d 1406 (9th Cir. 1984); *Stone & Webster Engineering Corp.* v. *Ilsley*, 690 F.2d 323 (2d Cir. 1982), *aff'd sub nom. Arcurdi* v. *Stone & Webster Engineering Corp.*, —— U.S. ——, 103 S.Ct. 3564 (1983). *Standard Oil Co.* v. *Agsalud*, 633 F.2d 760 (9th Cir. 1980); *aff'd mem.*, 454 U.S. 801 (1981); *Hewlett-Packard Co.* v. *Barnes*, 571 F.2d 502 (9th Cir.), *cert. denied*, 439 U.S. 831 (1978); *Michigan United Food & Commercial Workers Union* v. *Baerwaldt*, 572 F. Supp. 943 (E.D. Mich. 1983); *California Hospital Association* v. *Henning*, 569 F. Supp. 1544 (D.C. Cal. 1983); *Blue Cross and Blue Shield of Alabama* v. *Peacock's Apothecary, Inc.*, 567 F. Supp. 1258 (N.D. Ala. 1983); *Dawson* v. *Whaland*, 529 F. Supp. 626 (D.N.H. 1982).

Section 2807-a(6)(b), although part of a hospital cost containment law, is precisely the type of mandated benefit statute which this Court and the lower federal courts have held to be pre-empted by ERISA. Section 2807-a(6)(b), by granting Article 43 insurers such as Blue Cross a statutory discount rate while simultaneously denying self-insured plans the right to negotiate discounts, forces self-insured plans to choose between significantly reducing the benefits they now provide or switching to an Article 43 insurer such as Blue Cross. If the latter is chosen, the plans must provide the statutorily prescribed benefits which Article 43 mandates. *See* N.Y. Ins. Law § 4303. Section 2807-a(6)(b) thus creates an overriding economic incentive to provide only those benefits which New York State deems valuable.

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[8] This issue is currently being considered by this Court in *Attorney General* v. *Travelers Insurance Co.*, 391 Mass. 730, 463 N.E. 2d 548, *prob. juris. noted, sub nom. Metropolitan Life Insurance Co.* v. *Massachusetts*, —— U.S. ——, 105 S.Ct. 320 (1984).

That Section 2807-a(6)(b) seeks to accomplish indirectly, by legislative sanctions and incentives, what the New York State laws in *Shaw* sought to accomplish directly, by legislative mandate, is of no importance. ERISA Section 514(a) pre-empts laws of a "State," which ERISA Section 514(c)(2) defines as an instrumentality "which purports to regulate, *directly or indirectly*, the terms and conditions of employee benefit plans." 29 U.S.C. § 1144(c)(2) (emphasis added). As this Court explained in *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, after holding that New Jersey's workers' compensation law was pre-empted by ERISA:

> It is of no moment that New Jersey intrudes indirectly, through a workers' compensation law, rather than directly, through a statute called "pension regulation." ERISA makes clear that even indirect state action bearing on private pensions may encroach upon the area of exclusive federal concern . . . . ERISA's authors clearly meant to preclude the states from avoiding through form the substance of the pre-emption provision.

Id. at 525. Thus, New York may not, through economic sanctions and incentives in a hospital cost containment statute, attempt to mandate the benefits which employee benefit plans provide.

B. Section 2807-a(6)(b) Impermissibly Intrudes Upon The Decision Of Employee Benefit Plans To Be Structured On A Self-Insured Basis.

Section 2807-a(6)(b) creates a compelling economic incentive for employee benefit plans to forego their self-insured status. It thus runs directly counter to ERISA, which allows plan trustees to decide free from governmental interference whether to insure or self-insure. *See* 29 U.S.C. § 1002(1).

In *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, this Court struck down a state statute which, like Section

2807-a(6)(b), attempted to prohibit an trustees from doing that which ERISA allowed them to do. *Alessi* involved a New Jersey statute that prohibited pension plans from offsetting workers' compensation benefits against employee retirement benefits. Holding that the statute was pre-empted by ERISA, this Court concluded that the statute " 'relate[s] to pension plans governed by ERISA because it eliminates one method for calculating pension benefits—integration—that is permitted by federal law." *Alessi*, 451 U.S. at 524.

In reaching this conclusion, this Court acknowledged that "ERISA does not mention integration with workers' compensation . . ." *Id.* at 517. Nonetheless, because integration was implicitly permitted by federal law, and because Congress meant to establish employee benefit plan regulation as "exclusively a federal concern," *id.* at 523, the state law was held to be pre-empted.

It is immaterial that New York State, in Section 2807-a(6)(b), is attempting to regulate by economic sanction and coercion rather than, as in *Alessi*, by outright prohibition. In both cases, the States are impermissibly encroaching upon an area which Congress left to the sole discretion of plan trustees. Moreover, because ERISA explicitly allows funds to self-insure, this case represents an even more direct conflict with federal law than was the case in *Alessi*, where ERISA did not explicitly permit that which the state ought to outlaw. Accordingly, under the principles of *Alessi*, Section 2807-a(6)(b) must be held to be pre-empted.

C. Section 2807-a(6)(b) "Relates To" Employee Benefit Plans And Is Not Remote, Tenuous Or Peripheral To ERISA.

This Court has made clear that a law "relates to" an employee benefit plan within the meaning of Section 514(a) "if it has a connection with or reference to such a plan." *Shaw*, 103 S.Ct. at 2900. Section 2807-a(6)(b)'s

"connection with" self-insured employee benefit plans is manifest. Section 2807-a(6)(b) creates an economic compulsion for plans to forego their self-insured status and switch to coverage by an Article 43 insurer. By so doing, the statute forces these plans to abandon the benefit packages they now provide and adopt those which Article 43 insurers are required by statute to offer. A more direct "connection" is difficult to envision.

Section 2807-a(6)(b) also explicitly "refers to" employee benefit plans within the meaning of ERISA Section 514(a). Section 2807-a(6)(b), after granting Article 43 corporations such as Blue Cross a mandatory discount rate, immediately prohibits certain "self-insured and self-administered groups" from negotiating discount rates with hospitals. Other "self-insured and self-administered groups" are permitted to rely on their negotiated discount rate until December 31, 1985, at which time all negotiated rates will be disallowed. The law on its face thus regulates a critical aspect of how employee benefit plans function. This direct intrusion is precisely the type of regulation which Congress, in enacting ERISA Section 514(a), sought to prevent.

The court below attempted to circumvent these principles by holding that Section 2807-a(6)(b) was remote, tenuous and peripheral to ERISA. In so holding, the court determined that Section 2807-a(6)(b) merely affected a plan's "cost of doing business." *Rebaldo* v. *Cuomo*, 749 F.2d at 138-39. This conclusion is simply unsupportable.

Section 2807-a(6)(b) establishes economic sanctions and incentives which effectively dictate whether a plan may continue to operate on a self-insured basis. As stated, Section 2807-a(6)(b) requires self-insured plans to either drastically reduce the benefit packages they now offer or switch to an Article 43 insurer such as Blue Cross. If the latter choice is made, plans must provide

the benefits which Article 43 mandates and, in certain instances, cover certain persons who otherwise might not be covered. *See* N.Y. Ins. Law § 4305(c)(1) and note 5, *supra* at 6. Such a fundamental encroachment upon a plan's structure and functioning can hardly be characterized as a "mere cost of doing business."

The regulation at issue here bears little resemblance to that involved in *American Telephone & Telegraph Co.* v. *Merry*, 592 F.2d 118 (2d Cir. 1979). At issue in *Merry* was a state court judgment which ordered the garnishment of one person's pension income in order to enforce alimony and support obligations. 592 F.2d at 120. Thus, *Merry* involved the " 'ancient family law right' of maintenance and support," 592 F.2d at 122, which has always been treated "different[ly] from other laws." *Stone* v. *Stone*, 450 F. Supp. 919 (N.D. Cal. 1978), *aff'd*, 632 F.2d 740 (9th Cir. 1980), *cert. denied*, 453 U.S. 922 (1981). *See generally Savings & Profit Sharing Fund of Sears Employees* v. *Gago*, 717 F.2d 1038 (7th Cir. 1983); *Operating Engineers Local 428 Pension Trust Fund* v. *Zamborsky*, 650 F.2d 196 (9th Cir. 1981).

More importantly, the garnishment of one member's benefits, at issue in *Merry*, is fundamentally different from the legislation at issue here. The former, while perhaps generating some incidental administrative expenses to a plan, does not touch upon a plan's structure, administration and benefit package.[9] The latter, by at-

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[9] To the same effect is Lane v. Goren, 743 F.2d 1337 (9th Cir. 1984), another case on which the court below erroneously relied. The Ninth Circuit in *Lane* held that a California statute which prohibited an employee benefit plan acting as an employer from discriminating against the plan's own employees was not pre-empted. 743 F.2d at 1338. The statute did not purport to regulate the plan's structure or functioning as an employee benefit plan. Furthermore, prior to *Lane*, this Court in *Shaw* had explicitly stated that a law "prohibit[ing] employment discrimination in hiring, promotion, salary and the like" would not be pre-empted. 103 S.Ct. at 2900 n.17.

tempting to dictate how a plan is structured and what benefits it provides, is precisely the type of regulation of a plan *qua* plan which Congress explicitly pre-empted in ERISA Section 514(a).

D. In Giving Controlling Weight To New York's Interest In Hospital Cost Containment, The Court Below Stood The Legislative History And Purpose Of ERISA Section 514(a) On Its Head.

Recognizing that "[t]he breadth of § 514(a)'s pre-emptive reach is apparent from that Section's language," *Shaw*, 103 S.Ct. at 2899-90, this Court has characterized ERISA's expansive pre-emption clause as "virtually unique." *Franchise Tax Board of California* v. *Construction Laborers Vacation Trust for Southern California*, —— U.S. ——, 103 S.Ct. 2841, 2854 n.26 (1983). Indeed, unlike any other federal legislation, except for the narrow exceptions specified in the Act, the pre-emption of state laws which relate in any way to employee benefit plans is total.

The legislative history of Section 514(a) demonstrates that Congress deliberately employed the broadest possible language in order to occupy the field of employee benefit plan regulation. Congress enacted ERISA in response to a clearly perceived need for uniform, federal regulation of employee benefit plans. *See Shaw*, 103 S.Ct. at 2901; *Alessi*, 451 U.S. at 523. It determined that in order to remove the problem of increasingly intrusive and inconsistent state laws,[10] ERISA should fully displace state laws with a uniform body of federal law. Accordingly, Congress rejected earlier versions of a bill containing a

[10] Section 2807-a(6)(b) is precisely the type of intrusive state law which Congress sought to preempt. Among the plans affected by Section 2807-a(6)(b) are those, like the *Amici*, which are multi-state in scope. Requiring the plans here to forego self-insurance and switch to Blue Cross in New York would have a devastating effect on the plans' ability to self-insure in the other states in which their members live.

pre-emption clause which only displaced state laws relating to the specific subjects covered by ERISA. *Shaw*, 103 S.Ct. at 2900-01. Instead, it enacted a bill which, with the narrow statutory exceptions discussed above, sweepingly displaced state laws that in any way touched upon employee benefit plans. *Id.*

The decision below stands the legislative purpose of ERISA section 514(a) on its head by making the significance of the state interest at stake the touchstone of its analysis. The court below, throughout its decision, gave controlling weight to New York State's interest in hospital cost containment. By so doing, it ignored the fact that Section 514 pre-empts *all* state laws relating to employees benefit plans except for those specifically exempted. Hospital cost containment laws, however important, are nowhere on the statutory list of exemptions.

The impropriety of weighing the state interest at stake here becomes apparent upon an examination of this Court's decision in *Shaw*. New York's interest in eliminating sex discrimination, at issue in *Shaw*, is surely as important as its interest in hospital cost containment. In fact, the former interest, which is of constitutional dimension, is probably more weighty than the latter, which is merely an economic one. Nonetheless, this Court in *Shaw* refused to disturb the explicit federal-state accommodation struck by Congress in Section 514 by engaging in a balancing act. The court below should not be permitted to do so here.

CONCLUSION

For all of the foregoing reasons, the petition for a writ of *certiorari* should be granted.

Respectfully submitted,

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